August 26, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1656-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___is a gentleman who sustained a work-related injury resulting in chest pain and low back pain. He was followed by ___ who prescribed pain and sleep medications. He initiated a trial of pain control with a RS-4i sequential stimulator. According to ___, the patient did benefit from the stimulator. The patient's progress notes indicated on 3/11/03 that he had limited movement and pain all the time, difficulty sleeping, and pain when he used the stimulator. On follow–up he continued to have pain most of the time and he was still very limited in his movements. He stated that the stimulator helped manage his pain a little bit better and hopefully, on 5/14/03, he will get more and more relief with its use. ___ attempted to reduce the use of medication and was not successful. The request for the stimulator was an attempt to have other means of treatment for his pain. Reviews by ___ and ___, orthopedic surgeons, indicate that the patient's trial of the RS-4i stimulator did not meet clinical response criteria and in their opinion there was not literature to support the long-term use of a stimulator, and the services for home use of the device was denied.

REQUESTED SERVICE

The purchase of an RS-4i sequential stimulator 4-channel combination is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

From the information provided, the reviewer was not able to determine that the patient had an improvement in function and/or was able to decrease use of narcotic or pain medication. Therefore, the patient did not meet medical response criteria for the home-bound use of the RS-4i unit. The reviewer is aware of literature that does support the use of this unit, as well as literature that does not. The reviewer finds that in this case the clinical information does not support the long-term use of this device.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 26th day of August 2003.